ARTICLE

Working Parents

What Factors Are Involved in Their Ability to Take Time Off From Work When Their Children Are Sick?

S. Jody Heymann, MD, PhD; Sara Toomey, MPhil, MSc; Frank Furstenberg, PhD

Background: A series of studies has demonstrated that sick children fare better when their parents are present.

Objective: To examine working conditions that determine whether parents can spend time with and become involved in the care of their children when they are sick.

Design: Survey with a multivariate analysis of factors influencing parental care of sick children.

Participants: Mixed-income urban working parents aged 26 to 29 years participating in the Baltimore Parenthood Study.

Results: Only 42% of working parents in our sample cared for their young children when they became sick. A multivariate logistic regression analysis was conducted to predict which parents stayed at home when their children were sick. Those parents who had either paid sick or vacation leave were 5.2 times as likely to care for their children themselves when they were sick. Of parents with less than a high school education, 17% received paid leave, compared with 57% of parents with a general equivalency diploma, 76% of parents with a high school diploma, and 92% of parents with more than a high school education ($P<.001$).

Conclusions: The finding that many parents were unable to care for their sick children themselves is important for pediatric care. While low-income children are more likely to face marked health problems and to be in need of parental care, they are more likely to live in households in which parents lack paid leave and cannot afford to take unpaid leave.

Arch Pediatr Adolesc Med. 1999;153:870-874

Editor's Note: Once again, it seems that "them-what-has" continue to get more and vice versa. The findings are not surprising, they are disheartening.

Catherine D. DeAngelis, MD

From the Department of Health and Social Behavior, Harvard School of Public Health, Boston, Mass (Dr Heymann and Ms Toomey); and the Department of Sociology, University of Pennsylvania, Philadelphia (Dr Furstenberg).

HISTORICALLY, parents have played a critical role in the care of sick children. Young children need their parents or other care providers to take them to the physician when they are sick, to obtain and administer medicine, and to provide daily care when they are too sick to go to child care or school.

The percentage of mothers of preschool-aged children who work for pay has risen more than 5-fold over the past 50 years, from 12% in 1947 to 65% in 1997. The percentage of mothers of school-aged children who work for pay has almost tripled over the same period, from 27% to 78%.[1,2] While the number of working women with children has risen sharply, there has been no decline among working fathers. More than 95% of married men aged 20 to 44 years are in the labor force. As a result, most American children are now raised in households in which all parents present in the household work. However, the Family and Medical Leave Act (FMLA) covers only half of working parents, provides only unpaid leave, and does not cover many of children's routine illnesses.[3] The extent of the FMLA's coverage of parents with children with medical conditions is still under debate.

A series of studies has demonstrated that children recover more rapidly from illnesses and injuries when their parents are present.[4-6] The presence of parents has been shown to reduce the duration of hospital stays by 31%.[7] When parents are involved in children's care, children recover more rapidly from outpatient procedures as well.[8] Because of the importance of parental care, pediatricians have increasingly offered parents the chance to become involved in different aspects of the care for their children's health.[9,10]

MATERIALS AND METHODS

SURVEY SAMPLE

Primary data for this study were collected in the Baltimore Parenthood Study.[26] The Baltimore Parenthood Study was chosen because it is one of the few studies to examine the experience of moderate- and low-income parents who were at risk of facing difficulties caring for their sick children. Begun in 1966, the Baltimore Parenthood Study has evaluated teenage mothers, their children, and their grandchildren over the past 30 years. The latest wave of data collection occurred in 1995. We collected data on the experience of the third generation, who were aged 26 to 29 years in 1995 and had children aged 10 years or younger.

Table 1 presents demographic information, as well as work and family information, on the complete sample of individuals aged 26 to 29 years who were interviewed in the current data-collection wave. The table also presents comparative figures for those young parents who were the focus of our study: working parents with children aged 10 years or younger. The adult children in the Baltimore study are comparable with adult children of urban teenage mothers nationally.

PRIMARY DATA COLLECTION

These young parents were asked a series of questions that were developed specifically to examine what factors facilitated their ability to care for their children when they became sick. To the best of our knowledge, a similarly comprehensive series of questions has not been asked in any previous survey of low- and moderate-income families. Among other questions, parents were asked, when their child(ren) are sick on a day when they would normally work, whether they stayed at home and told those at work their child was actually ill or stayed at home and gave a different reason or gave no reason at all for missing work. Parents who responded that they stayed at home were asked what made it possible for them to stay at home with their child(ren). Their answers included paid leave to care for sick family members, their own paid sick leave, paid vacation or personal days, unpaid leave, flexible work hours, working at home, and other.

ANALYSES CONDUCTED

First, we examined how many parents cared for sick children themselves. Second, we examined what determined whether parents could stay home. This was examined both through parents' reports of how working conditions affected their ability to care for their children and through logistic regression analyses using actual work conditions and demographic characteristics to predict the probability that parents would care for their sick children themselves.

Table 1. Description of Sample*

	Total Sample, No. (%)	Parents Residing With Children, No. (%)	Parents Working and Residing With Children Aged ≤10 y, No. (%)
Total income, $/y			
≤9999	30 (16)	18 (16)	6 (8)
10 000-19 999	42 (22)	27 (24)	17 (23)
20 000-29 999	40 (21)	27 (24)	18 (24)
≥30 000	76 (40)	40 (36)	33 (45)
Education			
<High school	49 (22)	21 (17)	6 (8)
GED	20 (9)	14 (11)	8 (10)
High school	87 (38)	55 (45)	38 (49)
>High school	70 (31)	32 (26)	26 (33)
Welfare use			
Never	156 (69)	65 (53)	48 (62)
Ever	70 (31)	57 (47)	30 (38)
Hours worked/wk			
0	70 (31)	37 (30)	0 (0)
1-19	8 (4)	4 (3)	3 (4)
20-34	20 (9)	13 (11)	12 (15)
35-45	77 (34)	37 (30)	33 (42)
>45	51 (23)	31 (25)	30 (38)
Children, No.			
0	82 (40)	0 (0)	0 (0)
1	56 (27)	56 (46)	42 (54)
2	46 (23)	46 (38)	28 (36)
≥3	20 (10)	20 (16)	8 (10)
Marital status			
Married	58 (26)	44 (36)	35 (45)
Separated	16 (7)	7 (6)	4 (5)
Divorced	12 (5)	9 (7)	6 (8)
Single	140 (62)	62 (51)	33 (42)
Race†			
White	21 (9)	12 (10)	10 (13)
Black	172 (76)	93 (76)	55 (71)
Multiracial	32 (14)	17 (14)	13 (17)
Sex			
Male	110 (49)	37 (30)	25 (32)
Female	116 (51)	85 (70)	53 (68)
Occupation			
Managerial	24 (15)	10 (11)	8 (10)
Technical, sales	59 (37)	38 (44)	32 (41)
Service	39 (25)	17 (20)	17 (22)
Precision	9 (6)	6 (7)	6 (8)
Operator	27 (17)	16 (18)	15 (19)
Total Sample, No.	226	161	78

**Percentage of those reporting an answer. Percentages may not add to 100% because of rounding. GED indicates general equivalency diploma.*
†Self-reported.

Parents have been demonstrated to play important roles in the care of children with chronic as well as acute conditions.[11,12] The importance of parental involvement has been demonstrated for children with epilepsy,[13] asthma, and diabetes.[14-16] Receiving care from their parents is important for children's mental as well as physical health.[17,18] The detrimental effects of separating young children from their parents when they are sick have been repeatedly demonstrated.[19-21] When parental involvement in the care of sick children is increased, children's anxiety decreases.[22-25]

While the importance of parental involvement in caring for sick children has been well documented, little attention has been paid to the factors that influence whether parents can be involved in the care for their children's health. This article examines whether low-

Table 2. Parents Who Stayed Home With Their Sick Children by Job Benefits and Demographic Characteristics

	Parents Who Stayed Home With Sick Children, %
Job Benefits	
Paid sick leave*	
Yes	48
No	29
Paid vacation leave†	
Yes	49
No	19
Paid sick or paid vacation leave‡	
Yes	50
No	13
Demographic Characteristics	
Family income below 125% of poverty level*	
Yes	21
No	50
Single*	
Yes	33
No	52
≤High school education†	
Yes	32
No	58

*P≤.10.
†P≤.05.
‡P≤.01.

Table 3. Logistic Regression Predicting Probability of a Parent Staying Home to Care for a Sick Child*

Parental Characteristics	Multivariate Coefficient of Determination	z
Sick or vacation leave†	1.64	1.87
>High school education	0.57	0.86
Mother	0.62	0.77
Single	−0.72	−1.20
Family income below 125% of poverty level	−0.73	−0.88

*R^2 = 0.16.
†P = .06.

and middle-income parents who are currently working can spend time with and become involved in the care for their children when they are sick. It will document how many at-risk employed parents in one city were able to take leave from work to care for their children, and how many turned to someone else to care for their child. We also examine the conditions that determine whether parents care for their children when their children are sick.

RESULTS

WHO CARED FOR CHILDREN WHEN THEY BECAME SICK?

Of the working parents in our sample, 42% cared for their children when they became sick and 58% continued to go to work when their children were sick and left their children in the care of others. More than half of parents who were able to stay at home with their children when they were sick reported that the reason they could stay at home was that they received some type of paid leave; 29% were able to use paid vacation or personal days, 14% received paid leave to care for sick family members, and 11% were able to use their own paid sick leave. Only 11% used unpaid leave, 7% used flexible working hours, and 21% used different work benefits on different occasions.

Pearson χ^2 tests of the relationship between working conditions and whether parents stayed home when their children were sick confirmed that those respondents who received some type of paid leave were significantly more likely to stay home when their children were sick (**Table 2**). Parents who were single, living near or below the poverty level, or had a high school education or less were significantly more likely to need to stay at work when their children became sick (Table 2). The difference in the experience of single parents living in poverty with limited education was fully accounted for by the availability of paid benefits.

When a multivariate logistic regression analysis was conducted to predict which parents stayed at home when their children were sick, those parents who had either sick or vacation leave were 5.2 times as likely to care for their children themselves when they were sick. In the multivariate analysis, marital status, family income, and parental education were no longer significant predictors of parental response after controlling for paid leave (**Table 3**).

ROLE OF EDUCATION

Given the central role played by paid sick and vacation leave in determining which parents were able to care for their sick children, it was important to examine what determined whether parents had paid sick or paid vacation leave. Even small differences in educational attainment had a significant effect on whether parents had paid sick or paid vacation leave. Seventeen percent of parents with less than a high school education received paid leave, compared with 57% of parents with a general equivalency diploma, 76% of parents with a high school diploma, and 92% of parents with more than a high school education ($P<.001$). The effect of education remains significant in multivariate analyses, even after controlling for whether parents worked part-time or full-time and for income, sex, and race. Parents who had more than a high school education were 6.6 times as likely to have paid sick or vacation leave as those who did not ($P = .08$) (**Table 4**).

COMMENTS AND CONCLUSIONS

The overwhelming majority of children in the United States are now raised in households in which all parents present work. When young children become sick with common illnesses, someone needs to care for them.

Some have suggested that sick children should be cared for in institutional settings, such as sick child care centers or converted hospitals or clinics. Before we take

Table 4. Logistic Regression Predicting Likelihood of Receiving Paid Leave*

Parental Characteristics	Multivariate Coefficient of Determination	*z*
Beyond a high school education†	1.90	1.74
Works full time‡	2.95	3.15
Months at present job	–0.001	–0.09
Family income below 125% of poverty level	–0.79	–0.99
Female§	1.60	2.25

*$R^2 = 0.34$.
†$P < .10$.
‡$P < .01$.
§$P < .05$.

that step, we should review the lessons learned from past research regarding the care of sick children in hospitals. The evidence is clear. Even when institutional care is good, children fare better physically and mentally when their parents participate in their care. Furthermore, institutional care of sick children is not affordable for many families.

If parents are to provide sick child care, they will need to be allowed leave from work to care for sick family members. The findings in this study make it clear that providing paid leave of any kind to parents significantly increases their availability to care for their children. The finding that low-income parents and single parents with less than a high school education were less likely to be able to stay home with sick children is particularly important in light of the August 1996 welfare reform legislation that requires that the 4 million single mothers currently receiving welfare return soon to work.[27,28] Solutions exist. This study demonstrates that the rate at which single mothers living in poverty are able to stay with sick children is not significantly lower when they receive paid sick or paid vacation leave.

A 24-hour extension of the FMLA has been proposed to allow parents to care for children's routine illnesses (currently not covered by the FMLA), as well as to attend schools and meet other family needs. Such an extension would be useful but would not fully address the needs of low- and moderate-income families. Only those parents who are covered by the FMLA and who could afford unpaid leave would have 3 days when they could meet their children's needs. Currently, however, only half of all working parents are covered by the FMLA. Even if the FMLA is extended to include parents working for firms with fewer than 50 employees, the leave will remain unpaid. Our study demonstrates that paid leave is a far more important determinant of whether low- and moderate-income parents can care for their children when they are sick.

A more effective policy would be to guarantee all working parents the average amount of paid sick leave and paid vacation leave that is already provided by some American firms. Several public policy approaches could be taken to increase the availability of paid leave. Both private and public mechanisms could address the problem. Policies could be implemented through tax credits that recognize that helping American families is as important to the public good as energy conservation or capital investment, for which there are already tax savings for corporations. Alternatively, family leave insurance could be provided through mechanisms similar to that of worker's compensation or disability insurance.

The finding that many parents were unable to care for their sick children themselves is important for all families. It is particularly important for the parents of children living in poverty. Children living in poverty are at a higher risk of having significant problems with their health as well as failing to grow and develop at the same rate as their peers who are not living in poverty.[29-36] Furthermore, while low-income children are more likely to face marked health problems and to be in need of parental care for these problems, they are more likely to live in households in which parents lack paid leave and cannot afford to take unpaid leave. Because of this, it should not be surprising that lower-income parents in this study were less likely to stay home with their children than those with moderate incomes.

Accepted for publication December 16, 1998.

This research was funded by grants from the National Institute for Child Health and Development, National Institutes of Health, Bethesda, Md (Dr Heymann), and from the John D. and Catherine T. MacArthur Foundation Research Network on Successful Midlife Development, Vero Beach, Fla (Drs Heymann and Furstenberg), and by funding as a Seagrams Associate to the Canadian Institute for Advanced Research, Toronto, Ontario (Dr Heymann).

We thank Tim Brewer, MD, Harvard Medical School, Boston, Mass, for his thoughtful comments and Cara Bergstrom and Christine Kerr for their invaluable staff assistance.

Corresponding author: S. Jody Heymann, MD, PhD, Department of Health and Social Behavior, Harvard School of Public Health, 677 Huntington Ave, Boston, MA 02115.

REFERENCES

1. Bureau of Labor Statistics. Labor force statistics from the *Current Population Survey*. Available at: http://stats.bls.gov/news.release/famee.t05.htm. Accessed May 18, 1999.
2. Committee on Ways and Means, US House of Representatives. *1993 Green Book: Overview of Entitlement Programs*. Washington, DC: US Government Printing Office; 1993.
3. Heymann SJ, Earle A, Egleston B. Parental availability for the care of sick children. *Pediatrics*. 1996;98:226-230.
4. Mahaffy P. The effects of hospitalization on children admitted for tonsillectomy and adenoidectomy. *Nurs Rev*. Winter 1965;14:12-19.
5. Van der Schyff G. The role of parents during their child's hospitalization. *Aust Nurs J*. 1979;8:57-61.
6. Palmer SJ. Care of sick children by parents: a meaningful role. *J Adv Nurs*. 1993; 18:185-191.
7. Taylor MRH, O'Connor P. Resident parents and shorter hospital stay. *Arch Dis Child*. 1989;64:274-276.
8. Kristensson-Hallstron I, Elander G, Malmfors G. Increased parental participation on a pediatric surgical daycare unit. *J Clin Nurs*. 1997;6:297-302.
9. LaRosa Nash PA, Murphy JM. An approach to pediatric perioperative care: parent-present induction. *Nurs Clin North Am*. 1997;32:183-199.
10. George A, Hancock J. Reducing pediatric burn pain with parent participation. *J Burn Care Rehabil*. 1993;14:104-107.
11. Wolman C, Resnick MD, Harris LJ, Blum RW. Emotional well-being among adolescents with and without chronic conditions. *Adolesc Med*. 1994;15:199-204.

12. Hanson CL, DeGuire MJ, Schinkel AM, Henggeler SW, Burghen GA. Comparing social learning and family systems correlates of adaptation in youths with IDDM. *J Pediatr Psychol*. 1992;17:555-572.
13. Carlton-Ford S, Miller R, Brown M, Nealeigh N, Jennings P. Epilepsy and children's social and psychological adjustment. *J Health Soc Behav*. 1995;36:285-301.
14. Hamlett KW, Pellegrini DS, Katz KS. Childhood chronic illness as a family stressor. *J Pediatr Psychol*. 1992;17:33-47.
15. LaGreca AM, Auslander WF, Greco P, Spetter D, Fisher Jr EB, Santiago JV. I get by with a little help from my family and friends: adolescents' support for diabetes care. *J Pediatr Psychol*. 1995;20:449-476.
16. Anderson BJ, Miller JP, Auslander WF, Santiago JV. Family characteristics of diabetic adolescents: relationship to metabolic control. *Diabetes Care*. 1981;4: 586-594.
17. Waugh TA, Kjos DL. Parental involvement and the effectiveness of an adolescent day treatment program. *J Youth Adolesc*. 1992;21:487-497.
18. Sainsbury CPQ, Gray OP, Cleary J, Davies MM, Rowlandson PH. Care by parents of their children in hospital. *Arch Dis Child*. 1986;61:612-615.
19. Bowlby J. *Child Care and the Growth of Love*. London, England: Pelican; 1964.
20. Robertson J. *Young Children in Hospital*. 2nd ed. London, England: Tavistock Publications; 1970.
21. McGraw T. Preparing children for the operating room: psychological issues. *Can J Anaesth*. 1994;41:1094-1103.
22. Cleary J, Gray OP, Hall DJ, Rowlandson PH, Sainsbury CP, Davies MM. Parental involvement in the lives of children in hospital. *Arch Dis Child*. 1986;61:779-787.
23. Sainsbury CPQ, Gray OP, Cleary J, Davies MM, Rowlandson PH. Care by parents of their children in hospital. *Arch Dis Child*. 1986;61:612-615.
24. Gauderer MW, Lorig JL, Eastwood DW. Is there a place for parents in the operating room? *J Pediatr Surg*. 1989;24:705-706.
25. Hannallah RS, Rosales JK. Experience with parents' presence during anaesthesia induction in children. *Can Anaesth Soc J*. 1983;30:286-289.
26. Furstenberg FF. *Adolescent Mothers in Later Life*. New York, NY: Cambridge University Press; 1987.
27. *The Personal Responsibility and Work Opportunity Reconciliation Act of 1996*, 104th Cong, 2nd Sess (1996). Pub L No. 104-193.
28. Congressional Research Service. *New Welfare Law: The Personal Responsibility and Work Opportunity Reconciliation Act of 1996*. Washington, DC: Library of Congress; 1996. CRS Report for Congress. Publication EPW 96-687.
29. Montgomery LE, Kiely JL, Pappas G. The effects of poverty, race and family structure on US children's health: data from the NHIS, 1978 through 1980 and 1989 through 1991. *Am J Public Health*. 1996;86:1401-1405.
30. Bradley RH, Whiteside L, Mundfrom DJ, Casey PH, Kelleher KJ, Pope S. Early indications of resilience and their relations to experiences in the home environments of low birthweight, premature children living in poverty. *Child Dev*. 1994; 65:346-360.
31. Issler RM, Giugliani ER, Kreutz GT, et al. Poverty levels and children's health status: study of risk factors in an urban population of low socioeconomic level. *Rev Saude Publica*. 1996;30:506-511.
32. McGaughey P, Starfield B, Alexander C, Ensminger M. The social environment and vulnerability of low birthweight children: a social-epidemiological perspective. *Pediatrics*. 1991;88:943-953.
33. McLoyd V. The impact of economic hardship on black families and children: psychological distress, parenting and socioemotional development. *Child Dev*. 1990; 61:311-346.
34. Starfield B. Effects of poverty on health status. *Bull N Y Acad Med*. 1992;68: 17-24.
35. Watson JE, Kirby RS, Kelleher KJ, Bradley RH. Effects of poverty on home environment: an analysis of three-year outcome data for low birth weight premature infants. *J Pediatr Psychol*. 1996;21:419-431.
36. Wise PH, Meyers A. Poverty and child health. *Pediatr Clin North Am*. 1988;1169-1186.